MARYLAND STATE BOARD OF DENTAL EXAMINERS
Spring Grove Hospital Center ● Benjamin Rush Building
55 Wade Avenue • Catonsville, Maryland 21228

COMPLAINT FORM

PLEASE TYPE OR PRINT LEGIBLY IN BLACK OR BLUE INK.

The Maryland State Board of Dental Examiners (the "Board") regulates the practice of dentistry and dental hygiene in Maryland. The Board investigates complaints and may take disciplinary action against a licensee if the conduct in question is grounds for disciplinary action under the Dental Practice Act (Title 4 of Md. Code Ann., Health Occ.). This action may include a reprimand, probation, or suspending or revoking a license. The Board may also resolve the matter informally if there is no actual violation of the Dental Practice Act. **THE BOARD HAS NO JURISDICTION OVER COMPLAINTS THAT INVOLVE FEE DISPUTES OR REQUESTS FOR REFUNDS OR AGAINST A DENTIST OR DENTAL HYGIENIST WHO IS NOT LICENSED IN MARYLAND.**

If your complaint involves someone who is not licensed, the Board may refer the matter to the appropriate law enforcement agency for possible criminal prosecution. The Board may also refer complaints to a dental review committee for mediation.

Investigation and resolution of complaints take varying amounts of time. **THE BOARD IS PROHIBITED BY LAW FROM DISCLOSING INFORMATION REGARDING THE STATUS OF YOUR COMPLAINT OR ANY INVESTIGATION OR DISCIPLINARY ACTION THAT RESULTS FROM YOUR COMPLAINT UNTIL IT REACHES A FINAL DECISION.** If the Board takes formal disciplinary action, you will be entitled to a copy of the Board's order by making a request to the Board through the Public Information Act. **IF, HOWEVER, THE BOARD CLOSES THE CASE OR TAKES INFORMAL ACTION, THE BOARD IS PERMITTED ONLY TO TELL YOU THAT THE CASE HAS BEEN CLOSED.**

Complaints to the Board must be made on this form and signed and dated by the individual making the complaint. Often, a complaint is made available to the licensee so that he or she may file a response to the allegations with the Board. In certain types of cases, the Board has the discretion to withhold the identity of the complainant unless the licensee is charged. In all cases, however, the identity of a complainant and any medical records involved in the case are kept confidential and not released to the public, even if formal disciplinary action is taken, unless release of the information is necessary to protect the public or is otherwise required by law. If you have any questions, please contact the Board at 410-402-8538.

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK

1. IDENTIFY THE TYPE OF HEALTH PROVIDER
Place a check next to the appropriate provider.

_____ Dentist _____ Dental Hygienist
_____ Dental Radiation Technologist

2. IDENTIFY THE HEALTH PROVIDER- Please give the full name of the licensee you are complaining about. Not the name of the dental office.

a. Full Name: _____
(Please Print)

b. Office Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

c. Office Telephone: _____

3. PERSON MAKING THIS COMPLAINT

a. Full Name: _____
(Please Print)

b. Home Address _____
(Street Address)

_____
(City) (State) (Zip Code)

c. Home Telephone _____

d. Office Telephone _____

e. Patient's Date of Birth: ____/____/____

f. Patient's sex: M___ F____

4. PATIENT NAME (if different from person making this complaint)

a. Full Name: _____
(Please Print)

b. Home Address _____
(Street Address)

_____
(City) (State) (Zip Code)

c. Home Telephone _____

d. Office Telephone _____

e. Patient's Date of Birth: _____/_____/_____

f. Patient's sex: M____ F_____

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5a. Have you or the patient discussed your complaint with the dentist or dental hygienist against whom you made the complaint, prior to filing this complaint, and if so, what was the outcome? _____

_____

_____

_____

_____

_____

5b. Date(s) and of Place(s) occurrence(s) complained of: _____

_____

_____

_____

_____

_____

6. State the names, addresses, and telephone numbers of any witnesses to the occurrence(s) complained of, including any person(s) who were present at the time of the occurrence(s).

Name	Address	Telephone Number

7. List all other health care provider(s) that you have seen before, during or after the treatment you are complaining of.

Name	Address	Telephone Number

8a. Have you registered this complaint to any other person or organizations? _____

8b. If so, to whom? _____

_____

9. If the diagnosis and treatment that was rendered, which is the subject of this complaint, was paid by a third party insurer, identify insurer and patient's insurance identification number.

a. Insurance Identification Number: _____

b. Insurance Company Name: _____

c. Insurance Company Address: _____

10. Attach copies of any reports, bills, invoices, documents, or studies supporting or relating to your claim.

Copies of Supporting Documents Attached: _____ Yes _____ No
Do Not Attach Original Documents

11. Complaint
Please describe, with as much detail as possible, what event or events led to the filing of this complaint. Include in your description the dates and reason for seeing the health provider.

PLEASE TYPE OR PRINT _____

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ITEM 11: COMPLAINT (continued)

ITEM 11: COMPLAINT (continued)

12. **RELEASE OF MEDICAL RECORDS**

I hereby consent to the release to the Maryland State Board of Dental Examiners, or its designated investigating body, of medical reports and records related to this occurrence from any dental office, related institution, or dentist, including the dentist who is the subject of this complaint.

If the Maryland State Board of Dental Examiners determines that this complaint is a fee dispute, I consent to sending this complaint to the appropriate peer review entity or to the Consumer Protection Division of the Attorney General's office for mediation

_____Check Yes

If block is not checked, this complaint will be dismissed if the Board finds no probable violation of the Maryland Dental Act.

_____ _____

Date Signature of Complainant

13. **RELEASE OF ADDITIONAL INFORMATION**

I hereby consent to the release of any reports, responses, or any other material that the Maryland State Board of Dental Examiners deems necessary from my dental care provider who provided treatment to me whether or not this dental care provider is mentioned in any part of this complaint.

_____ _____

Date Signature of Complainant

14. **I HEREBY DECLARE AND AFFIRM** under the penalties of perjury that the matters and facts set forth in the foregoing complaint are true and correct to the best of my knowledge, information and belief.

_____ _____

Date Signature of Complainant

MAIL COMPLAINT TO:
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Spring Grove Hospital Center
Benjamin Rush Building
55 Wade Avenue
Catonsville, MD 21228

Complaintformrev05182007